

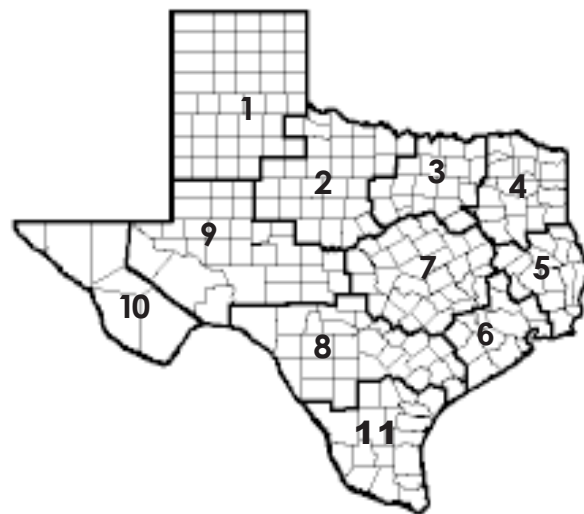
## The "Reporting Bowl": What's the Score?

*In previous years the first issue of Disease Prevention News typically focused on disease surveillance and the importance of reporting. This year, in addition to news regarding important upcoming changes, the Infectious Disease Epidemiology and Surveillance Division (IDEAS) is comparing 1995 and 1996 disease reporting data to evaluate the impact of the information provided. (We will not be able to assess 1997 surveillance activities for several months.) Not included are data on specified diseases that are reported to individual programs, such as Tuberculosis Elimination, HIV and STD Control, and Immunizations. The results of this 2-year comparison are thought provoking.*

**R**eporting increased an average of nearly 18% in Public Health Regions (PHRs) 4, 7, 8, and 11 (Figure 1). Case report totals decreased in the remaining regions. The percent decrease ranged from 7% in PHRs 3 and 6 to more than 40% in PHRs 2 and 9. Decreased reporting may reflect a true decrease in morbidity, but failure to report diagnosed cases is also probable. Underreporting is particularly frustrating since some studies have indicated that as little as 10% of notifiable conditions were actually reported.

Most of the year-to-year differences resulted from variations in the reporting of aseptic meningitis, hepatitis A, campylobacteriosis, salmonellosis, and shigellosis (Figure 2). Although the true incidence rates for these diseases may vary from year to year, extreme

### Public Health Regions



**Figure 1. Case Totals of Selected Conditions\* by Public Health Region (PHR), 1995 and 1996**

PHR	1995	1996	Increase/Decrease (%)
1	649	612	↓ 37 (5.7)
2	398	226	↓ 172 (43.2)
3	3121	2893	↓ 228 (7.3)
4	<b>458</b>	<b>557</b>	↑ <b>99 (17.8)</b>
5-N	131	105	↓ 26 (19.4)
5-S	194	160	↓ 34 (17.5)
6	2997	2774	↓ 223 (7.4)
7	<b>1382</b>	<b>1572</b>	↑ <b>190 (12.1)</b>
8	<b>1657</b>	<b>1891</b>	↑ <b>234 (12.4)</b>
9	633	346	↓ 287 (45.3)
10	774	638	↓ 136 (17.6)
11	<b>1542</b>	<b>2102</b>	↑ <b>560 (26.6)</b>

\*Does not include STDs, HIV/AIDS, TB, or vaccine-preventable diseases

annual differences in large populations would not be expected. For instance, in PHR 2, the morbidity rate (cases per 100,000 population) for shigellosis decreased markedly from 25.1 in 1995 to 5.0 in 1996. A comparison with the state rates of 16.2 in 1995 and 14.5 in 1996 suggests that this region may have experienced shigellosis outbreaks in 1995 and that cases were underreported in 1996. Likewise, in PHR 9, shigellosis rates were 45.8 in 1995 and 11.8 in 1996. It appears there were shigellosis outbreaks in PHR 9 in 1995, but the region more nearly mirrored the rest of

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*Also in this issue:*  
Post-Exposure Hotline

**Figure 2. Reported Rates for Selected Conditions by Public Health Region (PHR), 1995 and 1996\***

PHR	Aseptic Meningitis		Hepatitis A		Campylobacter Infection		Salmonella Infection		Shigella Infection	
	1995	1996	1995	1996	1995	1996	1995	1996	1995	1996
1	5.4	8.5	17.4	13.6	11.2	15.6	19.8	22.4	14.4	3.8
2	6.2	3.4	6.9	7.9	5.8	3.7	11.6	9.9	25.1	5.0
3	10.0	6.0	14.1	12.3	3.9	2.7	7.2	8.4	12.4	7.6
4	8.2	4.7	6.7	16.1	2.6	2.2	8.5	14.0	4.5	5.2
5	5.6	0.4	3.8	3.6	2.6	5.3	10.1	10.1	7.8	3.6
6	12.2	3.8	14.5	14.4	4.3	2.8	12.2	15.6	12.2	13.0
7	8.0	6.9	5.8	12.5	8.9	9.5	17.1	18.3	16.5	21.3
8	6.4	7.1	13.2	24.9	6.9	6.6	20.5	18.5	26.3	26.3
9	7.9	6.6	21.2	14.9	4.4	2.2	14.4	17.1	45.8	11.8
10	3.8	0.8	56.6	32.2	5.4	6.1	15.8	27.4	13.9	8.1
11	2.0	1.3	16.1	54.1	6.5	4.9	14.4	17.5	25.4	40.6
<b>State Total</b>	<b>8.4</b>	<b>4.9</b>	<b>16.1</b>	<b>18.2</b>	<b>5.3</b>	<b>4.7</b>	<b>12.7</b>	<b>14.8</b>	<b>16.2</b>	<b>14.5</b>

\*Expressed as rates (cases per 100,000)

the state in 1996. Shigellosis reporting in PHRs 4 and 5 was below the norm for both years.

Hepatitis A reporting underestimates the true incidence of disease. Even so, hepatitis A rates in PHRs 4 and 7 more than doubled from 1995 to 1996. In PHR 10, the hepatitis A rate in 1995 was 56.6, more than 3 times the state rate; the rate was still high (32.2) in 1996. However, this is not unusual since hepatitis A rates are often high in PHRs 10 and 11, which border Mexico. Hepatitis A rates in PHRs 2 and 5 were far below the state rate for these years. Along with underrecognition (young children with hepatitis A infection are often asymptomatic), underreporting limits the usefulness of hepatitis A reporting as a measure of control program efficacy. With the advent of hepatitis A vaccine, being able to measure the effectiveness of vaccine programs is particularly important.

Surveillance data, acquired through reporting, are used to monitor disease trends, respond to disease threats, identify risk factors for disease, and recommend and assess disease intervention/prevention strategies. In other words, reports are used to stop the spread of disease, improve public health and welfare, and reduce health care costs.

Local and state health departments need to be informed of each and every case of a reportable condition. Providing this information requires the commitment and cooperation of all health care providers. Perhaps year-end data from 1997 will be better. As we start 1998, let's challenge ourselves to a friendly competition and see which area of Texas improves the most next year!

### Probable Reporting Changes in 1998

Early in 1998 the Texas Board of Health will vote on amendments (additions and deletions to the list of reportable diseases) to the *Rules and Regulations Governing the Control and Reporting of Notifiable Conditions*. The most significant proposed changes concern the reporting of antibiotic resistant bacteria. In recent years there have been reports of drug-resistant *Streptococcus pneumoniae* (3,000 cases of meningitis and 7,000,000 cases of otitis media annually nationwide) and of vancomycin resistant *Enterococcus* species (for which there is no antibiotic therapy). There is also a potential for vancomycin resistant *Staphylococcus aureus*.

In parts of the United States where they are being monitored, resistance rates have recently risen dramatically. Because

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antibiotic-resistant organisms significantly affect antibiotic use and health care costs, data are needed to assess the problem and plan appropriate intervention strategies in Texas. Moreover, to curtail the progression of antibiotic resistance, IDEAS would like to provide health professionals with timely surveillance data detailing the incidence of resistant organisms in their communities.

The Board will also consider revisions of reporting rules for other emerging diseases. For instance, an increased incidence of Creutzfeldt-Jakob Disease (CJD) has been noted in Northeast Texas. CJD is characterized by a rapidly progressive dementia accompanied by severe muscle spasms and incoordination; death usually occurs within 6 to 12 months. Yersiniosis is a serious gastrointestinal illness that also appears to be becoming more common. Making these two conditions reportable will result in better case ascertainment and allow the department to identify risk factors and possible control measures.

Other proposed changes reflect new knowledge about etiologic agents of old diseases. It has recently been recognized that several spotted fever group rickettsia can cause Rocky Mountain spotted fever (RMSF)-like illnesses and more than one *Streptococcus* species can cause invasive disease. Therefore, it has been proposed that all spotted fever group rickettsioses (rather than only RMSF) and all invasive streptococcal disease (rather than only invasive group A) be reportable. Finally, reporting of tuberculosis infection in persons younger than 15 years of age is being deleted. Tuberculosis disease remains reportable.

### How To Report

Texas law requires designated professionals to provide specific information regarding certain diseases and other adverse health conditions.

Health care providers should call their local health departments when they

- ◆ receive laboratory results indicating that a patient has a reportable condition
- ◆ suspect that a patient has a reportable condition
- ◆ recognize an outbreak or something new
- ◆ think a patient may have exposed others
- ◆ think a situation exists that puts the public at risk

Diseases that spread rapidly or have serious consequences, unusual conditions, and outbreaks must be reported immediately. Tuberculosis and rubella cases are to be reported within one working day. Other reportable conditions should be reported within one week of identification. But the best rule to follow is to report as soon as possible. You can reach your local health department by calling **(800) 705-8868**. Health professionals may also call this number after hours and on weekends to report public health emergencies requiring immediate attention.

*Remember, by reporting you are fulfilling your legal obligations. Also according to Texas law, TDH assures that all reports are confidential.*

TDH remains committed to reducing as many reporting barriers as possible. Call (800) 252-8239 (and select choice #1) if you have suggestions for improving the reporting process. Health professionals may also use this phone number to reach TDH epidemiologists and physicians who are available to answer your questions and provide information.

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*We want to thank all of you who report accurately and consistently, year after year!*

***Happy New Year!***



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## Bloodborne Pathogens: Post-Exposure Hotline

Job-related exposures to serious bloodborne diseases occur daily among health care workers in the United States. On December 7 the Department of Health and Human Services launched a national, 24-hour-a-day, toll-free hotline to help clinicians counsel and treat health care workers with these types of injuries.

By calling **(888) 448-4911** from anywhere in the United States, clinicians can contact the National Clinicians' Post-Exposure Prophylaxis Hotline (PEpline). The PEpline has trained physicians who give information, counseling, and treatment recommendations for workers with needlestick injuries and other serious occupational exposures to bloodborne pathogens.

Hepatitis and HIV infection pose the greatest risk to health care workers with needlestick injuries. The Centers for Disease Control and Prevention (CDC) estimates that at least 5,000 HIV needlestick exposures occur annually. PEpline is a joint project of the Health Resources and Services Administration and the Centers for Disease Control and Prevention, in collaboration with the San Francisco Department of Public Health and the University of California at San Francisco.